STATE OF GEORGIA
GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2004 HOSPITAL FINANCIAL SURVEY
FOR HOSPITAL FISCAL YEARS ENDING DURING 2004

If you have any questions, please contact Brigitte Maddox at the Division of Health Planning at 404-656-0465 or bmaddox@dch.state.ga.us.

- IMPORTANT NOTICE ABOUT SURVEY COMPLETION and ACCURACY –

The information and data collected through this survey are used for state regulatory, planning, and reimbursement purposes and are made available to public officials, advocacy groups, health care purchasers, and consumers. The chief executive officer or principal administrator of the facility (who shall attest to the accuracy and completeness of the information provided) and your organization are responsible for ensuring the accuracy of the information and data reported in this survey. The sole responsibility for accuracy resides with the organization and the officials filing the survey. Accuracy at time of submission is particularly important.

This survey is required under O.C.G.A. § 31-6-70 and DCH Rule 111-2-2-.04 and other regulations. The failure to properly submit and/or fully complete all required surveys may adversely affect CON and ICTF determinations. Providing false or inaccurate information may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.04(1)(b), 111-2-2-.05(1)(a)1, and 111-2-2-.05(1)(a)7, other regulations and statutes, and may constitute a crime under O.C.G.A. §§ 16-10-20 and 16-14-1.

INSTRUCTIONS FOR COMPLETING THE SURVEY FORM

Step 1: When opened, the HFS database will be prompt you to enter your facility's password to access your survey. Your facility's password should have been included in the 2004 HFS notification letter and can also be obtained from DCH.

Step 2: After entering your facility password you will then be asked to "Compact and Repair" the database. This feature will remove prefilled records for other facilities and decrease the size of the database.

The database contains two types of forms (Survey Information Form and Signature Form). Both are described in greater detail below and can be accessed from the opening screen of the survey. Please enter a response for every item on the survey on each form. If an item does not apply to your facility please enter "not applicable" or zero. You will notice that certain items on the survey forms are blue in color. Click on these blue items to open specific instructions or examples related to the selected item.

THE SIGNATURE FORM

The Signature Form electronically authorizes the HFS and financial information provided in the survey for release to the Department of Community Health. The HFS must be signed to certify that the responses are complete and accurate for the report period specified. The Signature Form provides a space for the chief executive or principal administrator of the hospital to authorize the HFS. The signature of the chief executive or principal administrator is required. There is also a second signature space provided for the hospital's chief financial officer. A typed, electronic version of the signature is being accepted as an original signature pursuant to the Georgia Electronic Records and Signature Act.

Before the Signature Form will accept the administrator's signature certain data validation tests are required. These tests first determine if any required fields have been left blank and then verify that financial data is in balance. All edit and balance requirements and all required fields must be completed before the authorized signature can be entered on the Signature Form. You can determine if the required survey totals are in balance and that all required items are complete by clicking the "View Error Messages" button at the top of the Signature Form. This button produces the Error Messages Report containing a description of any out of balance totals and any required data items that are missing. This report can be printed and should be rerun until all items have been corrected. **Each item on the Error Messages Report must be corrected before the form will accept the authorized signature.**

Calculated Fields:

The Signature Form also will display a list of the calculated fields that are routinely used by the Department, the Division of Health Planning, the media and the public. The following fields will be calculated from the data you provide in other parts of the survey. These calculated fields are defined in the Calculations section below following the HFS Glossary of Terms. In some cases the formulas used by DCH may not be the same as those used by other organizations.

Financial Statistics	Indigent and Charity Care Statistics
Patient Gross Revenue	Reported Uncompensated Indigent/Charity Care
Total Deductions from Patient Revenues	Adjusted Gross Revenue (AGR)
Net Patient Revenue	Reported Indigent/Charity as % of AGR
Total Revenues	
Total Net Revenues	
Total Expenses	
Margin	
Margin Percent	
Cost to Charge Ratio	

These calculations are provided solely for the informational needs of the filing hospital. They do not represent an official statement or report from, or confirmation of survey acceptance by, the Department or the Division.

INSTRUCTIONS FOR SUBMITTING THE SURVEY

Once you have completed your survey and resolved any data validation issues, you should submit the survey to the Department of Community Health (DCH) via e-mail. Please follow the steps below:

1. You must sign the Signature Form before submitting your survey. The HFS will not be deemed complete without the authorized signature of the chief executive or principal administrator. Also, be sure that you have entered a response to every question and explained any anomalies in the space provided for comments on the signature form.
2. Please be sure to print a copy of your completed survey before submission or retain a copy of the Access file for your records. You can print a copy of the entire survey from the Opening Screen.
3. To submit your database, click the "Prepare Email to DCH" button on the Opening Screen and follow the instructions. A zip file will be created that you can easily attach to an email message. Send the email message to: dchsurveys@dch.state.ga.us. Attach additional files as necessary (see below). After you send the message you can check the Sent-Items box in your email program to see if the message was sent. You will not get an automated reply from DCH.
4. If the Email button does not work, close the database and create a new email message using your email program. Attach the database to the message as you would any file. The database should be located at C:\DCH unless it was moved after being downloaded initially. The database file will have an MDB extension. If your email system does not allow MDB attachments, you will need to rename the file before you send it. Change the MDB extension to MDX.

Survey Completion Status:

You should receive an auto-reply from the dchsurveys mailbox. This reply indicates that the email message was received by the DCH email system, but should not constitute an official notice of survey completion. DCH staff may not be able to process your survey immediately due to high volumes of email messages and survey submissions. You may follow-up a few days after submitting your survey to make sure your message was received and that your survey was processed and is considered complete by the Division of Health Planning. Even if processed at a later date, completed survey will be deemed complete on the day in which they were received at the dchsurveys email box. **It is extremely important that you retain a copy of your completed survey (both in Access and in hard-copy) in case DCH did not receive the email or the attachment was not able to be processed.**

PART A: GENERAL INFORMATION

Respond as requested. Please be sure to provide both the hospital's Medicaid and Medicare provider numbers. The hospital's name should appear as it was on the last day of the report period.

Report Period: The report period is the hospital's fiscal year that ended during calendar year 2004. Please make sure this section reflects beginning and ending dates of the hospital fiscal year. Generally, the fiscal year covered should agree with the report period covered in the hospital's cost report.

PART B: CONTACT INFORMATION

Provide the name, title, and phone numbers of the person authorized to respond to inquiries about the responses to the survey. This person must retain a copy of the completed survey.

PARTS C - F: FINANCIAL DATA AND INDIGENT AND CHARITY CARE

These parts of the survey must be completed by all hospitals. The data is required for health planning and certificate of need purposes pursuant to Chapter 6 of Title 31 of the Official Code of Georgia Annotated. O.C.G.A. § 31-6-70 outlines the requirement for the collection of certain data elements:

> *§ 31-6-70 (b) The report required under subsection (a) of this Code section shall contain the following information:*
> *(1) Total gross revenues;*
> *(2) Bad debts;*
> *(3) Amounts of free care extended, excluding bad debts;*
> *(4) Contractual adjustments;*
> *(5) Amounts of care provided under a Hill-Burton commitment;*
> *(6) Amounts of charity care provided to indigent persons;*
> *(7) Amounts of outside sources of funding from governmental entities, philanthropic groups, or any other source, including the proportion of any such funding dedicated to the care of indigent persons; and*
> *(8) For cases involving indigent persons:*
> *(A) The number of persons treated;*
> *(B) The number of inpatients and outpatients;*
> *(C) Total patient days;*
> *(D) The number of patients categorized by county of residence; and*
> *(E) The indigent care costs incurred by the hospital by county of residence.*

What to Include in HFS Financials:
Parts C-F of the survey should include financial data for the hospital only. You should exclude financial data from all other healthcare facilities operated by the hospital or the system. As a general rule, you should include financial data for services or programs that are operated under the hospital's license. Revenues associated with swing beds should be included, regardless of whether service was charged at hospital or nursing home rates.

What to Exclude from HFS Financials:
Financial data for hospital-based and other nursing home facilities, hospice, home health agencies, freestanding ambulatory surgery programs and primary care/physician offices should not be included in these sections of the survey.

PART C: FINANCIAL DATA ELEMENTS

Definitions and descriptions for each of the financial data elements, and certain calculations that result from this data, are included in the Glossary, which follows these instructions. The definitions are listed in the order in which the data element appears in the survey. Following each definition, as appropriate, are potential sources for the data element and possible reconciling items. Each hospital should evaluate its own cost reports, audits, and other financial records to determine the most accurate source for completing this survey. The information submitted in this survey is subject to compliance review and potential audit by the Department.

Important Note: While the financial data requested in the Hospital Financial Survey is based in general on AICPA guidelines, there are specific differences in the presentation of the data and the reporting requirements. In the case of a conflict, please use the reporting instructions and definitions provided for the Hospital Financial Survey.

Reference Material: The Healthcare Financial Management Association (www.hfma.org) provides guidance and resource materials that may assist hospitals with various financial management practices and principles. The following statements, in particular, address issues of relevance to the Hospital Financial Survey:

P & P Board Statement 15: Valuation and Financial Statement Presentation of Charity Service and Bad Debts by Institutional Health Care Providers

P & P Board Statement 16: Classifying, Valuing, and Analyzing Accounts Receivable Related to Patient Services

PART D. INDIGENT/CHARITY CARE POLICIES

IMPORTANT NOTE: The basis for determining qualification for indigent and/or charity care are the Federal Poverty Guidelines (FPG), which are established annually by the U.S. Department of Health and Human Services. The guidelines are available at the department website, www.dch.state.ga.us Hospital indigent and charity care policies should incorporate the most recent guidelines and income levels, in force at the time the determination for indigent and charity care was made, to be used in determining eligibility for services.

Indigent and Charity Care Policy Filing Requirements:

If your hospital had a formal written policy(ies) concerning the provision of indigent and charity care during the 2004 reporting period (as reflected in the answers to the questions in Part D of the survey), **you are required to file a copy of your policy(ies) with the Department** for 2004. Further, the charity care policy of the hospital guides the provision of such services and such a policy is required in order to allow the hospital to attribute any charges to charity care. A hospital that indicates on the survey that it has an indigent and/or charity care policy or that documents the provision of charity care must file a copy of the policy(ies) with the Division of Health Planning. These policies are a matter of public record and a required component of the Hospital Financial Survey.

PART D. INDIGENT AND CHARITY CARE POLICIES (Continued)

Please complete all items in Part D. Please note Part D, Question 5, which requires the hospital to detail the range of coverage provided under any established charity policy. In this section, the hospital should provide the upper level percentage of Federal Poverty Guidelines (FPG) for an individual or family that would be considered for charity care (e.g., 185%, 200%, 250%, etc.). The lowest threshold for charity care must always be above 125% of FPG. (For hospitals receiving ICTF funds, patients are considered medically indigent and eligible for charity services supported by ICTF funds if their income falls between 125% and 200% of FPG.) Responses in this section will be validated against the charity policy(ies) filed with the Department.

How to File Indigent and Charity Care Policies:

Please e-mail, fax, or send a copy of the following policies to the Division of Health Planning. Please be sure that the transmittal reflects the name of your hospital.

1. Your formal written indigent/charity care policy or policies.

2. Any agreement or agreements with any city or county concerning the receipt of government funds for indigent and/or charity care during the 2003 reporting period.

The policies should be sent to:

Georgia Department of Community Health
Attn: Brigitte Maddox
Division of Health Planning
#2 Peachtree Street NW; 34th Floor
Atlanta, GA 30303
email: bmaddox@dch.state.ga.us
FAX: 404-656-0654

PART E: INDIGENT AND CHARITY CARE REPORTING

For Items 1 and 2, please report Gross Charges associated with Inpatient and Outpatient Care for persons qualifying for Indigent Care (in accordance with state law) or Charity Care (in accordance with hospital policy).

For Items 3 through 12, please report by category all compensation received by the hospital to offset the cost of providing indigent or charity care. These amounts should include any direct compensation from local governments, hospital authority proceeds and private or charitable contributions. Further, hospitals should include funding provided by state programs (e.g., state cancer aid, vocational rehabilitation, etc.) if the patients receiving the state-funded service met the qualification for indigent or charity care. State program funding should be reported in Item 7**,** and Gross Charges related to the services provided should be included in Items 1 and 2 of this section. ***Indigent Care Trust Fund monies should not be included as state program funds and should not be included in this section or elsewhere in the survey.***

PART F. TOTAL INDIGENT AND CHARITY CARE BY COUNTY

Please report, by patient's county of residence, the number of inpatient and outpatient admissions/visits and related charges that may be attributed to persons qualifying for indigent and charity care as reported in Part E.

VALIDATION OF BALANCES IN PARTS C – F:

- Total uncompensated Indigent and Charity Care, as reflected in Part C, Items 8 and 9, should equal the net of Gross Indigent and Charity Care (Part E, Items 1 and 2) less all compensation received for such services (Part e, Items 3 through 12).
- Gross Inpatient and Outpatient Charges (Part E, Items 1 and 2) should equal Inpatient and Outpatient Charges by Indigent and Charity Care category reported in Part F.

PARTS G and H:

Part G and a new Part H of the 2004 HFS will collect financial information regarding Indigent Care Trust Fund allocations and determinations. For the 2004 HFS Parts G and H will be filed under a separate survey process. Your hospital will be notified regarding the Part G and H sections of the 2004 HFS by mail and these sections will be available in an Access database.

VALIDATION OF BALANCES IN PART G:

The following rules will be applied to compare totals between Part G and Parts C and E of the 2004 HFS. Hospitals are not required to conform to these conditions. These are considered the normal expectation of DCH, but any deviation from these norms should be explained by the hospital on the Signature Form.

- Total charges for Medicaid and Uninsured patients reported in Part G (Question 2A, 1) should not normally be greater than the Gross patient charges reported in Part C (Items 1 + 2).
- The Total Indigent and Charity Care charges to the ICTF program reported in Part G (Item 3) should normally be less than the Gross Indigent and Charity Care charges reported in Part E (Items 1 + 2).

PART I: OTHER SERVICES

Please list Revenues and Expenses for any additional cost centers that are also covered by the corporate or organizational system umbrella of your hospital, but that would not be reported in the HFS Parts A - F. These other services or programs would be owned or operated by the hospital or hospital system, but would not be specifically covered under the hospital's license as a hospital. These might include hospital-based or hospital-owned skilled nursing units, home health agencies, hospice facilities, diagnostic or imaging centers, or other operations from which the hospital draws revenue or expenses. These would be services or programs that were **not** included in Parts A – F of the HFS. Questions regarding Part I of the HFS should be referred to Brigitte Maddox at (404) 656-0465 or bmaddox@dch.state.ga.us.

HOSPITAL FINANCIAL SURVEY – GLOSSARY OF TERMS

DATA ELEMENTS IN PART C:

ITEMS 1 & 2. GROSS PATIENT REVENUE (INPATIENT AND OUTPATIENT)

1) Definitions:
   a) Gross Inpatient Patient service revenue is defined as room and board charges as well as ancillary charges for individuals registered as inpatients of the hospital.
   b) Gross Outpatient Patient service revenue is defined as charges for individuals registered as outpatients of the hospital.
   a) Gross patient service revenue should be reported on the basis of the gross charges to patients without consideration of contractual or other reductions.
   b) Patient service revenue should include only hospital services. Examples of exclusions from patient service revenues for the purposes of the Hospital Financial Survey are:
      i) Nursing Facility Revenues
      ii) Home Health Revenues
2) Potential sources for patient service revenue are:
      i) Audited financial statements
      ii) Medicare Cost Report Worksheets
         (1) Worksheet C
         (2) Worksheet G-2
         (3) Worksheet G-3
      iii) Internal financial statements or other internal records
      iv) Reported revenues from the above sources will likely require adjustment for purposes of the Hospital Financial Survey.
3) **Please do not include any UPL payments (gross or net) under patient revenue. Net UPL payments should be included as a <u>reduction</u> to Medicaid contractual adjustments**.

ITEMS 3, 4 & 5. CONTRACTUAL ADJUSTMENTS

1) Contractual adjustments represent any charges that are not paid by the third-party payers and cannot be billed to the patient pursuant to contractual agreements.
2) Contractual adjustments for Medicare, Medicaid and other payers are reported separately in the Hospital Financial Survey.
3) **IMPORTANT NOTES ABOUT MEDICAID CONTRACTUAL ADJUSTMENTS: Medicaid Contractual Adjustments should be reported without any reduction (positive offset) for net or gross monies received from the Indigent Care Trust Fund. Further, in the case of any other intergovernmental transfers related to Medicaid payments (frequently referred to as UPL payments), <u>the net payments only</u> should be considered a positive offset to Contractual Adjustments.**
4) PeachCare should be considered a Third-Party Payer (it is not Medicaid); therefore Contractual Adjustments related to PeachCare should be included under Other Contractual Adjustments.
5) Potential sources for contractual adjustments are:
   a) Supporting schedules for audited financial statements
   b) Internal financial statements or other internal records
   c) Contractual adjustments from the above sources may require adjustment for purposes of the Hospital Financial Survey.
      i) Potential reconciling items:
         (1) Noncovered charges eligible for treatment as indigent, charity or bad debt categories.
         (2) Contractual adjustments for services to other than hospital patients.

DATA ELEMENTS IN PART C (CONTINUED):

ITEM 6. HILL-BURTON OBLIGATIONS

Hill-Burton obligations reflect revenue forgone at full, established rates for uncompensated care provided under the hospital's Hill-Burton obligation, if any. Note that, for purposes of the HFS, Hill-Burton care is reported as a deduction from gross patient revenue, even though it may be disclosed only in the notes of the hospital's financial statement. Further note that care provided under a Hill-Burton obligation may not be considered indigent and charity care on the HFS and may not be counted in meeting an indigent or charity care commitment.

1) Amounts of care provided under a Hill-Burton commitment should be obtained from the Hill-Burton reports applicable to the hospital's fiscal year.
2) The amount of care provided to other than hospital patients should not be reported.
3) Potential sources for Hill-Burton obligations are:
   a) Hill-Burton reports
   b) Supporting schedules for audited financial statements
   c) Internal financial statements or other internal records.

ITEM 7. BAD DEBT

Bad debt is all hospital patient charges due from patients or other responsible parties which have not been or are not expected to be collected for patients identified as having income levels greater than 125% of Federal Poverty Guidelines (FPG) and which are not otherwise categorized as charity care, contractual adjustments, Hill-Burton, or other free care for the purposes of the HFS. Indigent and charity care are provided to patients with a demonstrated inability to pay as documented in accordance with state law and hospital policy. Bad debt results from the unwillingness of a patient to pay the charges for which the patient is responsible;

1) Definitions
   a) An amount that some party has an obligation to pay but that is not collected. Bad debts represent the portion of a patient's account not collected from the patient or other responsible party (the patient's portion).
   b) The patient's portion of a bill should not be categorized or treated as a bad debt for patients whose income is less than or equal to 125% of the federal poverty guidelines unless the patient is paying for the service.
   c) Bad debts must be differentiated from charity services. Patients otherwise eligible for classification as charity care cases should be included in the bad debt category if all conditions of the charity care definition are not met.
   d) Charges for Medicare, Medicaid and other third-party payers not qualifying for treatment as contractual adjustments may be classified as bad debts if not categorized as indigent or charity.
2) Potential sources for bad debts are:
   a) Audited financial statements
   b) Internal financial statements or other internal records
   c) Reported bad debts from the above sources will likely require adjustment for purposes of the Hospital Financial Survey.
   d) Potential reconciling items:
      i) Bad debts eligible for treatment as charity or Hill-Burton write-offs which might otherwise qualify as bad debt had the individual not met the definition and received services in accordance with indigent, charity or Hill-Burton policies.
3) **IMPORTANT NOTE: For the Hospital Financial Survey, bad debt is reported as a deduction from patient revenue. As such, when reporting Total Expenses, please DO NOT include Bad Debt as an expense.**

DATA ELEMENTS IN PART C (CONTINUED):

ITEM 8. INDIGENT CARE

Indigent care is defined as revenue forgone for services to income tested patients whose individual or family income is less than or equal to the 125% of the Federal Poverty Guidelines (FPG). Optimally, the patient's ability to pay should be evaluated at the time of hospital admission and the patient should be advised that he or she qualifies for indigent care. In certain instances, such notification and classification may be withheld pending additional information from the patient to the hospital accounts office. The accounts of patients classified as indigent will generally be kept in a separate log. Patient accounts generally should be classified as indigent care at the time of admission or shortly thereafter. Once classified as indigent due to the patient's inability to pay for services, these accounts should never be turned over to a collection agency.

1) Unpaid (and, generally, unbilled) charges for services to income tested patients whose family income is less than or equal to 125% of the Federal Poverty Guidelines are reported as indigent.
2) Potential sources for contractual adjustments are:
   a) Supporting schedules for audited financial statements
   b) Internal financial statements or other internal records
   c) Indigent logs.
3) Potential reconciling items:
   a) Write-offs of services to other than hospital patients.

Please note: The Indigent Care amount reported in Part C should reflect Uncompensated Indigent Care. The uncompensated Indigent and Charity Care figures reported in Part C. 8 and 9, when combined, should balance to the calculated net indigent and charity care balance in Part E (Gross Charges Less Compensation Received).

ITEM 9. CHARITY CARE

Charity care is defined as revenue forgone for services to income tested patients whose individual or family income is greater than 125% of the Federal Poverty Guidelines (FPG) and whose charges for such services were written off to a valid charity account in the hospital's accounting records pursuant to a formal and official written charity policy. Frequently, charity policies provided for a sliding fee scale, which allows for a portion of the charges to be written off to charity care while the patient remains responsible for payment of the remainder of the charges. The charity policy should outline the financial and other qualifications of patients for waiver of some or all of the charges for services provided. Patients should be apprised of the provisions of any charity care policy prior to services being rendered and, optimally, the patient's ability to pay should be evaluated at the time of admission into service and the patient should be advised if he or she qualifies for charity care. In certain instances, such notification and classification may be withheld pending additional information from the patient to the hospital accounts office. The accounts of patients classified as charity care will generally be kept in a separate log. The portion of a patient's bill that is recognized for charity care due to the inability to pay for services should never be turned over to a collection agency.

1) Definitions:
   a) Charity care represents health care services that are provided but payment is not expected.
   b) Charity care is provided to a patient with demonstrated inability to pay.
   c) Only the portion of a patient's account that meets the organization's charity care criteria is recognized as charity.
   d) Charity care is defined as:
      i) Unpaid charges for services to income tested patients whose family income is greater than 125% of the Federal Poverty Guidelines, and
      ii) Have been provided in accordance with the hospital's formal written charity care policy, and
      iii) Have been written off to a formal charity account in the hospital's accounting records.
2) Potential sources for charity care are:
   a) supporting schedules for audited financial statements
   b) Internal financial statements or other internal records
   c) Charity logs or other detail reports.
3) Potential reconciling items:
   a) Write-offs of services to other than hospital patients.

Please note: The Charity Care amount reported in Part C should reflect Uncompensated Charity Care. The uncompensated Indigent and Charity Care figures reported in Part C. 8 and 9, when combined, should balance to the calculated net indigent and charity care balance in Part E (Gross Charges Less Compensation Received).

DATA ELEMENTS IN PART C (CONTINUED):

ITEM 10. OTHER FREE CARE

1) Other free care includes uncompensated services as a result of employee discounts, administrative discounts, courtesy discounts, or other similar discounts not based on a patient's inability or unwillingness to pay or on contractual agreements with third-party payers.
2) Potential sources for free care are:
   a) Supporting schedules for audited financial statements
   b) Internal financial statements or other internal records.
3) Other free care from the above sources may require adjustment for purposes of the Hospital Financial Survey.

NOTE ON DATA CALCULATIONS: For purposes of the Hospital Financial Survey, ITEMS 3 –10 (Contractual adjustments, Hill Burton Obligations, Bad Debt, Indigent Care, Charity Care, and Other Free Care) are considered reductions from (or offsets to) gross revenues.

ITEM 11. OTHER REVENUES/GAINS

1) Definitions
   a) Other revenues/gains are derived from services other than providing services to patients.
   a) Other revenues/gains should include those revenues reported in the audited financial statements as other operating revenue, other revenue and non-operating revenue.
2) Examples of other revenues/gains are:
   a) Interest and dividends
   b) Rental of health care facility space.
   c) Sales of medical and pharmaceutical supplies to employees, physicians and others.
   d) Proceeds from sale of cafeteria meals and guest trays to employees, medical staff and visitors.
   e) Proceeds from the sale of scrap.
   f) Proceeds for sales at gift shops, parking lots and other service facilities operated by the hospital.
4) If other operating revenues, other revenue or non-operating revenues are shared with entities other than the hospital, the revenues should be allocated between the entities using an appropriate allocation method.
5) **INDIGENT CARE TRUST FUND payments of any type should be excluded from this category.**
6) Potential sources for the above revenues are:
   a) Audited financial statements
   b) Medicare Cost Report Worksheets
      i) Worksheet G-3
   c) Internal financial statements or other internal records
   d) Reported revenues from the above sources will likely require adjustment for purposes of the Hospital Financial Survey.

ITEM 12. TOTAL EXPENSES

1) Definitions
   a) The sum of resources consumed in fulfillment of a hospital's ongoing major or central operations. Expenses may result from current expenditures, incurring obligations to make future expenditures, or consuming resources obtained from previous expenditures.
   b) Expenses associated with non-hospital services should be excluded from the Survey.
   c) Expenses related to activities shared with entities other than the hospital should be allocated between the entities. The expense component not allocated to the hospital should be eliminated from the Survey.
   d) Appropriate matching of the revenues and expenses excluded from the Survey should be made.
2) Potential sources for operating expenses are:
   a) Audited financial statements
   b) Medicare Cost Report Worksheets
      i) Worksheet A
   c) Internal financial statements or other internal records.
3) **Please do not include Bad Debt as an expense. For purposes of the Hospital Financial Survey, bad debt is reported as a deduction from patient revenue.**

HOSPITAL FINANCIAL SURVEY -- CALCULATIONS

ADJUSTED GROSS REVENUE: Adjusted Gross Revenue (AGR) is calculated by subtracting Medicaid and Medicare contractual adjustments *only* and bad debt from the hospital's total gross revenues. AGR is used as the basis for determining a hospital's level of uncompensated indigent and charity care services. Generally, these figures are presented as a percentage of the hospital's AGR. For those hospitals that have a CON commitment to provide indigent and charity care, the commitment (usually expressed as a percentage) is multiplied by the AGR to calculate the amount of uncompensated indigent and charity care that the hospital is required to provide.

COST TO CHARGE RATIO: Cost to Charge Ratio is calculated by dividing total operating expenses by gross patient revenue. The figure, generally expressed as a percentage, represents the relationship between the hospital's reported operating expenses to the patient charges for services during a common reporting period.

MARGIN: For purposes of the HFS, Margin is calculated by subtracting total expenses from total net revenues. The Margin is frequently used as one proxy for the financial health and stability of the facility. It is important to note that the HFS does not represent itself as an audited financial statement nor is the HFS designed to assess institutional or system stability or viability. However, hospitals should recognize that the data is used by associations, public officials and the media for these purposes.

MARGIN PERCENT: The margin percent represents margin as a percentage of total net revenues. It is calculated by dividing the margin by the total net revenues.

NET PATIENT REVENUE: This figure represents Gross Patient Revenue (Part C, Items 1 and 2) less reported deductions from revenues (Part C, Items 3 through 10).

TOTAL GROSS REVENUE: Total Gross Revenue is the sum of Gross Patient Revenue plus any other revenues or gains (Part C, Item 11).